UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF ILLINOIS

IN RE YASMIN AND YAZ (DROSPIRENONE) MARKETING, SALES PRACTICES AND RELEVANT PRODUCTS LIABILITY LITIGATION	)	3:09-md-02100-DRH-CJP MDL No. 2100

PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who used Yaz® and/or Yasmin® and/or Ocella®. Whether completing this fact sheet for yourself or for someone else, please assume that "You" means the Yaz® and/or Yasmin® and/or Ocella® user.

In filling out this form, please use the following definitions: (1) "**health care provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; (2) "**document**" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

You may attach as many sheets of paper as necessary to fully answer these questions.

I. CASE INFORMATION

1. Name of person completing this form: _____

2. Please state the following for the civil action that you filed:

   a. Case caption: _____

   b. Docket Number: _____

   c. Court in which action was originally filed: _____

   d. Name, address, telephone number, fax number and email address of principal attorney representing you:

      Name: _____

      Firm: _____

      Address: _____

      Telephone Number: _____ Fax Number: _____

      E-mail Address: _____

3. If you are completing this Plaintiff Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

   a. Your name:

      _____

   b. Current Address: _____

   c. In what capacity are you representing the individual or estate: _____

   d. If you were appointed as a representative by a court, state the:

      Court Which Appointed You: _____

      Date of Appointment: _____

      _____

   e. What is your relationship to the individual you represent: _____

      _____

THE REST OF THIS PLAINTIFF FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO USED YAZ® AND/OR YASMIN® AND/OR OCELLA®

II. PERSONAL INFORMATION

1. Name: _____

2. Maiden or other names used and dates you used those names: _____

_____

3. Current Address and Date when you began living at this address: _____

_____

4. Identify each address at which you have resided during the last ten (10) years, and the dates you resided at each one.

Address	Dates of Residence

5. Social Security Number: _____

6. Date and Place of Birth: _____

7. Current Marital Status: _____

8. If married, has your spouse filed a loss of consortium or other claim?

Yes _____ No _____

9. Occupation of current spouse: _____

10. Name(s) of current and former spouse(s), date(s) of marriage(s) and dates the marriage(s) were terminated, if applicable, and the nature of the termination (*e.g.*, death, divorce):

_____

_____

_____

11. If you have children, please identify each child's name, address and date of birth.

Child's Name and Address	Date of Birth

12. Identify all schools you attended, starting with high school:

Name of School	Address and Telephone Number	Dates of attendance	Degree Awarded	Major or Primary Field

13. Are you currently employed? Yes_____ No_____

If "Yes", please identify your current employer and position there: _____

_____

a. Did you ever leave this job for a medical reason? Yes_____ No_____

If "Yes", describe why you left: _____

_____

14. Have you ever served in any branch of the military? Yes _____ No _____

a. Branch and dates of service: _____

If "Yes", were you ever were discharged for any reason relating to your medical, physical or psychiatric condition?

Yes _____ No _____

If "Yes", state what that condition was: _____

b. Have you ever been rejected from military service for any reason relating to your medical, physical, or psychiatric condition?

Yes _____ No _____

If "Yes", state what that condition was: _____

_____

15. Identify each insurance carrier with whom you had health insurance coverage at any time beginning ten (l0) years prior to using Yaz® and/or Yasmin® and/or Ocella® (or the age of 13, whichever is later) up to the present, and please include all private insurance and public assistance if applicable:

Name of Insurance Company	Policy Number	Name of Policy Holder/Insured (if different than you)	Approx. Dates of Coverage

16. Have you applied for workers' compensation, social security, or state or federal disability benefits within the past ten (l0) years?

Yes _____ No _____

If "Yes", then as to each application, separately state:

a. Date (or year) of application: _____

b. Type of benefits: _____

c. Nature of claimed injury/disability: _____

d. Period of disability: _____

e. Amount awarded: _____

f. Basis of your claim: _____

g. Was claim denied? Yes_____ No_____

h. To what agency or company did you submit your application:

_____

i. Claim/docket number, if applicable:_____

17. Have you ever been denied life insurance for reasons relating to your health?

Yes_____ No_____ I don't know_____

If "Yes", please state when the denial occurred, the name of the life insurance company, and the company's reason for denial:

_____

_____

18. Have you ever filed a lawsuit other than the present suit, relating to any bodily injury within the past ten (10) years?

Yes_____ No_____

If "Yes", please explain the nature of the case, where it was filed, and identify your lawyer:

_____

_____

_____

19. In the last 10 years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to any crime that involved an alleged act of dishonesty or providing a false statement?

Yes_____ No_____

If "Yes", please state the charge to which you pled guilty to or were convicted, as well as the court where the action was-pending: _____

_____

III. HEALTH CARE PROVIDERS AND PHARMACIES

1. Identify each doctor or other health care provider who you have seen for medical care and treatment in the past ten (10) years:

Doctor or Health care Provider's Name	Doctor or Health care Provider's Specialty	Address	Reason for Visit	Approx. Dates/Years of Visits

2. Identify each hospital, clinic, or health care facility where you were hospitalized (inpatient, out-patient, or emergency room visit) in the past ten (10) years:

Name	Address and Telephone Number	Admission Date(s)	Reason for Admission Approx dates/years of visits

3.

4. Identify each pharmacy that has dispensed medication to you in the past ten (10) years:

5.

Name of Pharmacy	Address and Telephone Number of Pharmacy	Name of medication dispensed	Approx. Dates/Years You Used Pharmacy

IV. MEDICAL BACKGROUND

1. Current Height:_____

2. Current Weight:_____

3. Approximate weight immediately before using Yaz® and/or Yasmin® and/or Ocella®:_____

4. Approximate weight at the time of your injury:_____

5. Approximate date and age of your first menstrual period:_____

6. **Tobacco Use History:** For the three (3) year period prior to your use of Yaz® and/or Yasmin® and/or Ocella® up to the present Check the answer and fill in the blanks applicable to your history of tobacco use, including cigarettes, cigars, pipes, and/or chewing tobacco/ snuff.

7. ___ I have never used tobacco.

8. ___ I used tobacco in three year period prior to my use of Yaz® and/or Yasmin® and/or Ocella®

9. Type(s) of tobacco used (cigarettes, cigars, pipes, smokeless tobacco, snuff)_____

10. Approximate Date tobacco use started: _____

11. Approximate Amount used: _____

12. ___ I currently use tobacco

13. Type(s) of tobacco used (cigarettes, cigars, pipes, smokeless tobacco,

14. snuff)_____

15. Approximate Date tobacco use started: _____

16. Approximate Amount currently using: on average ___ per day for __ years

17. ___ I have used different amounts of tobacco at different times (please identify type(s) of tobacco used and dates of use below).

18. _____

19. _____

20. **Alcohol Consumption**: For the one (1) year period prior to your use of Yaz® and/or Yasmin® and/or Ocella® up to the present, did you drink alcohol (beer, wine, etc.)?

21. Yes _____ No _____

22. If "Yes", fill in the appropriate blank with the number of drinks that best represents your approximate average alcohol consumption during that time:

23. _____drinks per week, or

24. _____drinks per month; or

25. _____drinks per year; or

26. Other (describe): _____

27. **Caffeine Consumption**: For the one (1) year period prior to your use of Yaz® and/or Yasmin® and/or Ocella® up to the present, did you consume caffeinated beverages (*e.g.*, coffee, tea, soda):

28. Yes _____ No _____

29. (a) If "Yes", fill in the appropriate blank with the number of drinks that best represents your approximate average alcohol consumption during that time:

30. _____drinks per week, or

31. _____drinks per month; or

32. _____drinks per year; or

33. Other (describe): _____

34. (b) State the type of caffeinated beverages consumed (*e.g.*, coffee, tea, soda):

35. _____
___

36.
_____

37. State whether in the 30 day period prior to the onset of the injuries for which recovery is sought in this action, you engaged in any prolonged travel (meaning six hours or longer), such as sitting in an airplane or a long car trip, and set forth the date of such travel, and provide a description of such prolonged travel, including date(s) and method(s) of travel:

_____

_____

_____

38. Have you ever been diagnosed with or sought treatment for any of the following conditions? Please select "Yes", "No" or "Unknown" for each condition.

(a) For each condition for which you answer "Yes", please provide the additional information requested in subpart (b):

Condition	Yes	No	Unknown
1. Abnormal genital bleeding			
2. Abnormality of blood vessels or circulatory system			
3. Acne (within one year of use of Yaz®/Yasmin®/Ocella®)			
4. Adrenal insufficiency			
5. Alcoholism			
6. Allergy, such as hay fever, asthma, eczema, hives, sensitivity to drugs and other substances			
7. An abnormal physical condition symptomatic of any disease such as edema of the extremities, pain in the extremities, prolonged (longer than 1 week) subnormal or elevated temperature, recurring headaches, jaundice			
8. Aneurysm			
9. Angina or chest pain			
10. Anorexia or bulimia			
11. Any blood clotting disorder			
12. Arteriovenous malformation (AVM)			
13. Autoimmune disease or condition such as lupus, rheumatoid arthritis, psoriasis, scleroderma, or mixed-connective tissue disorder			
14. Bleeding disorder			
15. Blood clots or thrombosis			

Condition	Yes	No	Unknown
16. Blood disorder or dyscrasia			
17. Brain tumors			
18. Cancer - Breast			
19. Cancer - Cervical			
20. Cancer - Endometrial			
21. Cancer - Other form of Cancer			
22. Cerebrovascular disease or condition			
23. Coronary artery disease or other heart disease			
24. Cystitis			
25. Deep Vein Thrombosis (DVT)			
26. Diabetes			
27. Ectopic Pregnancy			
28. Elevated Cholesterol			
29. Gastrointestinal disease such as gallbladder disease, colitis, intestinal obstruction, liver dysfunction			
30. Glandular disease, such as malfunction of the pancreas, parathyroid, thyroid, adrenal, or pituitary			
31. Gout			
32. Heart attack			
33. Heart valve disease or abnormality			
34. Hepatic dysfunction or active liver disease			
35. Hypercoagulable conditions (*e.g.*, conditions, whether genetic or acquired, in which your blood clots too much)			
36. Hypertension or high blood pressure			
37. Hypotension			
38. Increased C-reactive protein (CRP) levels			
39. Infectious disease, such as tuberculosis, pneumonia, rheumatic fever, syphilis, gonorrhea, typhoid fever, encephalitis, poliomyelitis, malaria or hepatitis			
40. Irregular heart beat, atrial fibrillation, arrhythmia, heart palpitations, tachycardia (rapid heart beat), bradycardia (slow heart beat)			
41. Jaundice			

Condition	Yes	No	Unknown
42. Kidney disease or impaired kidney function			
43. Liver tumor			
44. Migraine or other headaches with neurological symptoms			
45. Mitral valve prolapse			
46. Neurological disease or condition (such as Parkinson's disease, paralysis)			
47. Ovarian cysts			
48. Peripheral vascular disease			
49. Portal Vein Thrombosis			
50. Premenstrual dysphoric disorder (or "PMDD")			
51. Premenstrual syndrome (or "PMS")			
53. Pulmonary Embolism (PE)			
54. Retinal bleed			
55. Rheumatological condition			
56. Seizure disorder or epilepsy			
57. Shortness of breath			
58. Stroke or brain hemorrhage (any type)			
59. Transient Ischemic Attack (TIA)			
60. Varicose veins			
61. Vasculitis			

(b) For each condition for which you answered "Yes" in the previous chart, please provide the information requested below (and attach additional pages as necessary):

Condition	Approximate Date of Onset	Name, Address and Telephone Number of Treating Health Care Provider or Health Care Facility

V. ADDITIONAL MEDICATIONS

1. Do you currently take, or have you ever taken in the last ten (10) years, any of the following medications (generic name is followed brand name products in [brackets]):

Name of Medication	Yes	No	Not sure/ Unknown/ Do Not Recall
1. ACE inhibitors (*e.g.*, captopril [Capoten], enalapril maleate [Vasotec], lisinopril [Zestril] benazepril [Lotensin], fosinopril [Monopril], moexipril [Univasc], perindopril [Aceon], quinapril [Accupril], ramipril [Altace], trandolapril [Mavik])			
2. Aldosterone antagonists (*e.g.*, spironolactone [Aldactone], eplerenone [Inspra])			
3. Angiotensin-II receptor antagonists (*e.g.*, losartan [Cozaar], valsartan [Diovan], irbesartan [Avapro], candesartan [Atacand], eprosartan [Teveten], olmesartan [Benicar], telmisartan [Micardis])			
4. Antibiotics (*e.g.*, ampicillin, tetracycline, griseofulvin)			
5. Anticoagulants (*e.g.*, Coumadin, Warfarin, Fragmin, Lovenox, or Heparin)			
6. Anticonvulsants (*e.g.*, Phenobarbital, phenytoin [Dilantin], carbamazepine [Tegetrol])			
7. Any medications for migraine headaches			
8. Ascorbic acid [Vitamin C]			
9. Asthma/breathing medications			
10. Atorvastatin [Lipitor]			
11. Blood pressure medications			

Name of Medication	Yes	No	Not sure/ Unknown/ Do Not Recall
12. Diuretics			
13. Heart medications (excluding aspirin)			
14. Minocycline (*e.g.*,[Myrac, Dynacin])			
15. NSAIDs (*e.g.*, ibuprofen [Motrin, Advil], naproxen [Naprosyn, Aleve])			
16. Phenylbutazone			
17. Potassium supplement			
18. Potassium-sparing diuretics (*e.g.*, amiloride [Midamor], triamterene [Dyrenium])			
19. Rifampin [Rifadin]			
20. St. John's Wort (hypericum perforatum)			
21. Thyroid Medications			

(a) If you indicated "Yes" for any of the above medications/drugs, please provide the information requested below (and attach additional pages as necessary):

Name of Medication/Drug Used	Dates of Use (approx.)	Name, Address and Telephone Number of prescribing Health Care Provider or Health Care Facility

2. Are there any prescription medications that you have taken on a regular basis in the past ten (10) years?

Yes_____ No_____

(a) If "Yes", please for each prescription medication provide the following information:

Name of Prescription Medication Used on a Regular Basis	The health care provider(s) that Prescribed the Medication	Approximate dates/years taken	Your understanding as to why you were taking the Medication

3. For the 20 days before the onset of the injuries for which recovery is sought in this action, please identify whether you have taken/ingested any of the following:

Name of Medication/Drug/Supplement	Yes	No	Do Not Recall
1. Ephedra			
2. Prescription diet medications			
3. Cocaine/crack cocaine			
4. Attention deficit medications			
5. Heroin or methadone			

Name of Medication/Drug/Supplement	Yes	No	Do Not Recall
6. Marijuana or hashish			
7. LSD, ecstasy, ICE, PCP, MDMA			
8. Amphetamines			
9. Inhaled non-prescriptive substances (*e.g.*, glue or toluene)			
10. Caffeine pills containing stimulants (*e.g.*, No-Doz, Vivarin)			
11. Over the counter appetite suppressants			
12. Dietary supplements			
13. Herbal products			
14. Steroids			

(a) If you indicated "Yes" for any of the above medications/drugs, please provide the information requested below (and attach additional pages as necessary):

Name of Medication/Drug/Supplement	Approximate Date used (that is ***within*** 20 days of your alleged Yaz® and/or Yasmin® and/or Ocella® related injury)

4. ***Except for the medications/drugs/supplements identified in question 3 above, for the twenty (20) day period before the onset of the injuries for which recovery is sought in this action***, set forth: (a) the name of each and every over the counter and prescription drug product ingested or otherwise used by you (including all vitamins, nutritional supplements, and all herbal and homeopathic medications and remedies); (b) the date of each ingestion or use; (c) the dosage ingested and frequency of use; (d) the purpose for using each such product; (e) the prescribing physician, if any; (f) the pharmacy or store where the product was purchased; and (g) the date of purchase. Attach additional sheets as necessary.

Name of over-the-counter or prescription drug:	Date(s) of ingestion or use:	Dosage ingested or used and frequency:	Purpose of use:	Prescribing health care provider (if any):	Pharmacy or store where purchased:	Date of purchase:

VI. PREGNANCY HISTORY

1. Have you ever been pregnant? Yes_____ No _____

   a. If "Yes", state your total number of pregnancies: _____

   b. If "Yes", state your total number of live births: _____

   c. If "Yes", indicate below whether during pregnancy, you were diagnosed with or believe you experienced any of the following:

Name of Condition	Yes	No	Unknown	If "Yes", state approx. date(s)
Toxemia				
Gestational Diabetes				
Pre-eclampsia				
Miscarriages				

VII. FAMILY MEDICAL HISTORY

1. Please indicate, to the best of your knowledge, whether your parents, sibling, or grandparents have ever suffered from any of the following:

Condition	Yes	No	I Don't Know
1. Abnormality of blood vessels			
2. Aneurysm			
3. Angina or chest pain			
4. Arteriovenous malformation			
5. Autoimmune disease or condition (*e.g.*, lupus, rheumatoid arthritis, psoriasis, scleroderma, or mixed connective tissue disorder)			
6. Bleeding disorder			
7. Blood clots or thrombosis or any other blood clotting disorder			
8. Blood disorders or dyscrasias (abnormal blood cells)			
9. Brain Tumors			
10. Cancer			
11. Cerebrovascular disease or condition			
12. Deep vein thrombosis (DVT)			
13. Diabetes			
14. Elevated Cholesterol			
15. Glandular disease (such as malfunction of the pancreas, parathyroid, thyroid, adrenal or pituitary)			
16. Heart attack			
17. Heart disease			
18. Heart valve disease or abnormality			
19. Hypercoagulable conditions			
20. Hypertension or high blood pressure			
21. Hypotension			
22. Increased C-reactive protein (CRP) levels			
23. Infectious disease (within the past year, such as tuberculosis, pneumonia, rheumatic fever, typhoid fever, encephalitis, poliomyelitis, malaria, or hepatitis)			

Condition	Yes	No	I Don't Know
24. Irregular heart beat, atrial fibrillation arrhythmia, heart palpitations, tachycardia (rapid heart beat), bradycardia (slow heart beat)			
25. Migraine			
26. Mitral valve prolapse			
27. Neurological disease or condition (such as Parkinson's disease or paralysis)			
28. Peripheral vascular disease			
29. Phlebitis			
30. Portal vein thrombosis			
31. Pulmonary Embolism (PE)			
32. Retinal bleed			
33. Rheumatological condition			
34. Seizure disorder or epilepsy			
35. Stroke of any type or brain hemorrhage			
36. Transient ischemic attack (TIA)			
37. Varicose veins			
38. Vasculitis			

(a) For each condition for which you answered "Yes" in the immediately preceding chart, please provide the information requested below (and attach additional pages as necessary):

Condition	Date of Onset (approx.)	Relationship to You	Treatment and Outcome (If known)	Name and Address of Treating health care provider or health care facility (If known)

VIII. USE OF CONTRACEPTIVES OTHER THAN YAZ® AND/OR YASMIN® AND/OR OCELLA®

1. Did you use contraceptives before your use of YAZ® and/or Yasmin® and/or Ocella®?

   Yes___ No___

2. If Yes, what contraceptives have you used in the past *before* you used YAZ® and/or Yasmin® and/or Ocella®? Check all that apply below.

Form of Contraception	Yes	No	Unknown
(a) Oral contraceptives (*e.g.*,. birth control pills)			
(b) Norplant (*e.g.*,. implants under skin)			
(c) Depo-Provera® (the shot)			
(d) NuvaRing®			
(e) Transdermal contraceptives (*e.g.*, Ortho Evra®)			
(f) Intrauterine device (IUD)			
(g) Contraceptive sponge			
(h) Diaphragm			
(i) Condoms			
(j) Spermicide			
(k) Rhythm method			
(l) Other			

For each "*Yes*" you have checked above, provide the following:

Form of contraception (*i.e.*, precise name/type of product): _____
Approx length of use (*i.e.*, months/years):_____
Pharmacy where prescription was filled (if applicable):_____
Health care provider who prescribed it:_____

Form of contraception (*i.e.*, precise name/type of product): _____
Approx length of use (*i.e.*, months/years):_____
Pharmacy where prescription was filled (if applicable):_____
Health care provider who prescribed it:_____

Form of contraception (*i.e.*, precise name/type of product): _____
Approx length of use (*i.e.*, months/years):_____
Pharmacy where prescription was filled (if applicable):_____
Health care provider who prescribed it:_____

IX. YAZ® AND/OR YASMIN® AND/OR OCELLA® USE

1. Have you ever used Yaz®? Yes_____ No _____

2. Have you ever used Yasmin®? Yes_____ No _____

3. Have you ever used Ocella®? Yes_____ No _____

If "Yes", identify:

a) Date(s) of use:_____ _____

b) Provide in the chart below the name(s) and address(es) of the health care provider(s) who prescribed or provided Yaz® and/or Yasmin® and/or Ocella® to you:

Name of health care provider(s)	Address of health care provider(s)

c) Provide in the chart below the name(s) and address(es) of the pharmacy(ies) or other store(s) or location(s) from which you obtained Yaz® and/or Yasmin® and/or Ocella® (if samples were provided, see no. 5, below):

Name of Pharmacy or Other Store/Location	Address

4. Do you claim that you took Yaz® and/or Yasmin® and/or Ocella® to treat PMDD, PMS or acne?

PMDD: Yes_____ No_____

PMS: Yes_____ No_____

Acne: Yes_____ No_____

If you checked "Yes" for PMDD or PMS in the preceding questions, please state whether you saw a psychiatrist, psychologist or other mental health care provider for PMDD, PMS or the symptoms of PMDD or PMS or any psychiatric and/or psychological condition(s) relating to PMDD or PMS in the last ten (10) years:

Name of psychiatrist, psychologist or other mental health care provider	Address and Telephone	Reason for Treatment	Approx. Dates/ Years of Treatment/ Visits

5. Did you receive any samples of Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____ I don't recall_____

If "Yes", please state the following:

a) Who gave you the sample(s): _____

b) When were samples provided: _____

c) How many samples did you get? _____

6. Were you given any written instructions, including any prescriptions, packaging, package inserts, literature, or dosing instructions with your Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____ I don't recall_____

If "Yes", who gave you the instructions? _____

_____

7. Were you given any oral instructions regarding your use of Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____ I don't recall_____

If "Yes", who gave you the instructions? _____

_____

8. Do you have in your possession or does your attorney have the packaging from the Yaz® and/or Yasmin® and/or Ocella® you alleged to have used?

Yes_____ No_____

If "Yes", who currently has custody of the Yaz® and/or Yasmin® and/or Ocella® packaging? _____

_____

9. Do you know the lot number(s) for any of the Yaz® and/or Yasmin® and/or Ocella® you received?

Yes_____ No_____

If "Yes", what is/are the lot number(s): _____

10. Do you know the expiration date for any of the Yaz® and/or Yasmin® and/or Ocella® you received?

Yes_____ No_____

If "Yes", when is/was/were the expiration date(s): _____

11. Have you ever seen any advertisements (*e.g.*, in magazines or television commercials) for Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____

If "Yes," identify the advertisement or commercial, and approximately when you saw the advertisement or commercial: _____

_____

_____

_____

12. Other than through your attorneys, have you had or do you believe you have had any communication, oral or written, with any of the Defendants or their representatives (including E-mail, Text Messages, E-Minders to/from you and any of the Defendants including through websites for Yaz® and/or Yazmin® and/or Ocella® and/or signing up for an on-line program)?

Yes_____ No_____ I do not recall_____

Yes_____ No_____ I do not recall _____

If "Yes," set forth the date of the communication, the method of communication, the name of the representative you communicated with, and the substance of the communication between you and any representatives of the Defendants: _____

_____

_____

X. INJURIES & DAMAGES

1. Are you claiming any injury as a result of taking Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____

If "Yes," please describe in detail your physical injury(ies) you claim were caused as result of your use of Yaz® and/or Yasmin® and/or Ocella®:

_____

_____

_____

_____

_____

a. When did this/these injury(ies) occur?_____

_____

_____

_____

_____

b. Were there any witnesses when your injury occurred or for the period of one (1) hour before your injury occurred, and if so, please state his/her/their name(s), address(es) and his/her/their relationship to you?

_____

_____

_____

c. If you were taken to a doctor or health care facility (*e.g.*, hospital or clinic) to be treated for the injury(ies), state the name and address of the persons, police department, fire department, emergency medical workers, or ambulance company who took you to the doctor or health care facility:

Name	Address

d. Were you hospitalized for this/these injury(ies)? _____

Yes_____ No_____

If "Yes", please provide the following information:

Approximate date(s) of hospital admission	Approximate date(s) of discharge	Hospital name(s) and address(es):

2. Do you claim that your use of Yaz® and/or Yasmin® and/or Ocella® caused or aggravated any psychiatric and/or psychological condition(s)?

Yes_____ No_____

(a) If "Yes", please state the following as it pertains to your treatment of any psychiatric and/or psychological condition(s) in the last ten (10) years:

Name of psychiatrist, psychologist or other mental health care provider	Address and Telephone	Reason for Treatment	Approx. Dates/ Years of Treatment/ Visits

3. **NOTE: ANSWER THIS QUESTION ONLY** if you are alleging and claiming that you suffered a stroke or other brain injury or cognitive impairment as a result of your Yaz® and/or Yasmin® and/or Ocella® use. If so, then please answer the following:

(a) Have you been treated in the last ten (10) years for any cognitive or learning problem?

Yes_____ No_____

(b) If "Yes", please state the following as it pertains to your treatment for any cognitive or learning problem in the last ten (10) years:

Name of treatment provider	Address and Telephone	Reason for Treatment	Approx. Dates/Years of Treatment/ Visits

4. Are you making a claim for lost wages or lost earning capacity?

Yes_____ No_____

(a) If "Yes", state for the last five (5) years the Annual gross income you derived from your employment:

Year	Annual gross income

5. If you are making a claim for lost wages (or are claiming a stroke, other brain injury, or cognitive impairment) identify the following for each employer you have had in the last five (5) years:

Name and Address of Employer	Approx. Dates of Employment	Occupation/Job Title	Supervisor	Reason for Leaving

6. Have you had any communications with your health care providers, orally or in writing, about whether your condition is related to your use of Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____ I don't recall_____

(a) If "Yes", please identify the name, address and approximate date of communication with said health care provider:

_____

_____

7. Have you spent any money as a result of using Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____

(a) If "Yes", please identify and itemize all out-of-pocket expenses you have incurred:

XI. FACT WITNESSES

1. Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your health care providers, and please state their name, address and his/her/their relationship to you (attach additional pages as necessary):

Name	Address	Relationship to You

XII. DOCUMENT DEMANDS

A. AUTHORIZATIONS

1) **Health care Authorizations** – For each health care provider identified in Sections III; IV; V; VII; VIII; IX and X, please provide a completed and signed (but undated) Health care Authorization in the form attached as **Exhibit "A."**

2) **Tax Return 4506 and 4506-T IRS Forms** –

a) Only if you answered "Yes" to question X.4 in the PFS and are asserting a claim for lost wages or a reduction in lost earning capacity, please provide a completed and signed IRS Form 4506 and 4506-T attached as **Exhibit "B"** for each year identified in your answer to question X.4.

b) If you answered "No" to question X.4 in the PFS and are not asserting a wage loss claim or a reduction in lost earning capacity, you are not required to provide IRS Form 4506 / 4506-T.

3) **Authorizations for the Release of Employment Records** – If you are 1) asserting a claim for lost wages or a reduction in or lost earning capacity or 2) claiming a stroke, other brain injury, or cognitive impairment, please provide a completed and signed Employment Authorization attached as **Exhibit "C"** for each employer identified in your answer question X.5.

4) **Authorization for Release of Workers' Compensation Records** – If you answered "Yes" to question II.16 in the PFS, stating that you applied for workers' compensation within the past ten (l0) years, please provide a completed and signed (but undated) Authorization for Release of Workers' Compensation Records for each agency or company you submitted your application to in the last 10 years in the form attached as **Exhibit "D."**

5) **Authorization for Release of Disability Records** - If you answered "Yes" to question II.16 in the PFS, stating that you applied for disability within the past ten (l0) years, please provide a completed and signed (but undated) Authorization for Release for each agency or company you submitted your application to in the last 10 years in the form attached as **Exhibit "E."**

6) **Educational Records** - If you are 1) asserting a claim for lost wages or a reduction in or lost earning capacity or 2) claiming a stroke, other brain injury, or cognitive impairment, please provide a completed and signed Educational Authorization attached as **Exhibit "F"** for each educational institution for each educational institution that you listed in response to question II.12.

7) **Insurance Records Authorization**- For each company listed in your response to question II.15 in the PFS, please provide a completed and signed (but undated) Authorization for Release of Insurance Records in the form attached as **Exhibit "G".**

B. FEDERAL DISCLOSURES REQUIRED PURSUANT TO 42 U.S.C. § 1395y(b)(7) and (b)(8)

Starting on January 1, 2010, Defendants must report to the federal government certain information about every Plaintiff making a personal injury claim. Please complete the Federal Disclosure statement attached to the end of this Plaintiff Fact Sheet as **Exhibit "H".**

C. OTHER RELEVANT DOCUMENTS

Documents in your possession, including writings on paper or in electronic form (if you have any of the following materials in your custody or possession, please indicate which documents you have and attach a copy of them to this Plaintiff Fact Sheet):

1. All non-privileged documents you reviewed that assisted you in the preparation of the answers to this Plaintiff Fact Sheet. Yes_____ No_____

2. A copy of all medical records and/or documents relating to the use of Yaz® and/or Yasmin® and/or Ocella®; from any hospital or health care provider who treated you in the past 10 years and who treated you for any disease, condition or symptom referred to in any of your responses to the questions above and concerning any condition you claim is related to the use of Yaz® and/or Yasmin® and/or Ocella®, including, but not limited to, all imaging studies of any part of your body that relate in any manner to the diagnosis, treatment, care or management of your condition and the injuries alleged in your Complaint. Yes_____ No_____

3. If you have been the claimant or subject of any workers' compensation, social security or other disability proceeding, all documents relating to such proceeding. Yes_____ No_____

4. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Yaz® and/or Yasmin® and/or Ocella®. Yes_____ No_____

5. Copies of advertisements or promotions for Yaz® and/or Yasmin® and/or Ocella® and articles discussing Yaz® and/or Yasmin® and/or Ocella®. Yes_____ No_____

6. Copies of the entire packaging, including the box and label for Yaz® and/or Yasmin® and/or Ocella® (plaintiffs or their counsel must maintain the originals of the items requested in this subpart). Yes_____ No_____

7. All documents relating to your purchase of Yaz® and/or Yasmin® and/or Ocella®, including, but not limited to, receipts, prescriptions, prescription records, containers, labels, or records of purchase. Yes_____ No_____

8. All documents known to you and in your possession which mention Yaz® and/or Yasmin® and/or Ocella® or any alleged health risks or hazards related to Yaz® and/or Yasmin® and/or Ocella® in your possession at or before the time of the injury alleged in your Complaint, other than legal documents, documents provided by your attorney or documents obtained or created for the purpose of seeking legal advice or assistance. Yes_____ No_____

9. All documents in your possession or anyone acting on your behalf (not your lawyer) obtained directly or indirectly from any of the Defendants. Yes_____ No_____

10. All documents constituting any communications or correspondence between you and any representative of the Defendants. Yes_____ No_____

11. All photographs, drawing, journals, slides, videos, DVDs or any other media relating to your alleged injury or your life after the incident. Yes_____ No_____

12. Copies of all documents you (and not your lawyer) obtained from any source related to Yaz® and/or Yasmin® and/or Ocella® or to the alleged effects of using Yaz® and/or Yasmin® and/or Ocella®. Yes_____ No_____

13. If you claim you have suffered a loss of earnings or earnings capacity, your federal tax returns for each of the last five (5) years or W-2s for each of the last five years. Yes_____ No_____

14. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care providers. Yes_____ No_____

15. All public statements made by or on behalf of you relating to this litigation in your possession. Yes_____ No_____

16. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable). Yes_____ No_____

17. Decedent's death certificate and autopsy report (if applicable). Yes_____ No_____

XIII. DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the documents requested in Part XII of this Plaintiff Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the Authorizations attached to this declaration.

Date:_____ _____

Signature

EXHIBIT-A

(Healthcare Authorization)

LIMITED AUTHORIZATION TO DISCLOSE AND HEALTH INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO: _____

Patient Name: _____
DOB: _____
SSN: _____

I, _____, hereby authorize you to release and furnish to: **Sidley Austin/Eckert Seamans/Williams & Connolly/Litigation Management Inc.** **COPIES ONLY** of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All reports of autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

1. To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the defendants and has been approved by the Court supervising this litigation. This authorization is for the sole purpose of allowing copies of my medical records to be provided to the defendants in this litigation. It does not allow discussions of my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition.

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name:_____(plaintiff/representative)
Signature: _____ _____
Date

EXHIBIT-B

(IRS Forms)

Form **4506**

(Rev. January 2010)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b **First social security number on tax return or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	2b **Second social security number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Caution. *If the tax return is being mailed to a third party, ensure that you have filled in line 6 and line 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.*

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1040

Note. *If the copies must be certified for court or administrative proceedings, check here* . . . . . ☑

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

12/31/2002	12/31/2003	12/31/2004	12/31/2005
12/31/2006	12/31/2007	12/31/2008	

8	**Fee.** There is a $57 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$ 57.00
b	Number of returns requested on line 7	7
c	Total cost. Multiply line 8a by line 8b	$ 399.00
9	If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here	☑

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note.** *For tax returns being sent to a third party, this form must be received within 120 days of signature date.*

Sign Here	Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a
	Title (if line 1a above is a corporation, partnership, estate, or trust)		
	Spouse's signature	Date	

Form **4506-T**
(Rev. January 2010)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can also call 1-800-829-1040 to order a transcript. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Caution. *If the transcript is being mailed to a third party, ensure that you have filled in line 6 and line 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.*

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ 1040

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☑

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days. . ☑

c **Record of Account,** which is a combination of line item information and later adjustments to the account. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days . . . . . ☑

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☑

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2007, filed in 2008, will not be available from the IRS until 2009. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days . . . ☑

Caution. *If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.*

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12/31/2005	12/31/2006	12/31/2007	12/31/2008

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of signature date.*

Sign Here	Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a
	Title (if line 1a above is a corporation, partnership, estate, or trust)		
	Spouse's signature	Date	

EXHIBIT-C

(Employment Authorizations)

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508
EMPLOYMENT AUTHORIZATION

TO: _____
Name of Employer

_____
Address, City State and Zip Code

RE: Employee Name:_____ AKA:_____

Date of Birth: _____Social Security Number: _____

Address:_____

I authorize the disclosure of my employment records including any medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and complete records including the following:

This will authorize you to furnish copies of all applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; performance evaluations, reviews and reports; transfers, statements and comments of fellow employees; all documents relating to discipline including warnings, reprimands, suspensions, terminations, and all other forms of discipline; attendance records; W-2s, worker's compensation files; all medical records, x-rays and test results; any physical examination records; all documents relating to my absences, illnesses and injuries; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf; and any other records relating to my employment and/or in my personnel file.

Information about HIV/AIDS and alcohol/substance abuse may be disclosed.

I authorize you to release the information to:

_____
Name (Records Requestor)

_____
Street Address City State and Zip Code

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires December 31, 2011 or at the conclusion of the case, whichever occurs first.

_____
Signature of Employee or Personal Representative Date Name of Employee or Personal Representative

_____
Description of Personal Representative's Authority to Sign for Employee (attach documents that show authority)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Employee is physically unable to provide a signature. I personally witnessed that the Employee understood the nature of this authorization and freely gave her verbal consent to release her medical records.

_____ _____

EXHIBIT-D

(Workers' Comp. Authorizations)

AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all workers' compensation records of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requester
_____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____
Claimant Signature
[NAME]

Date: _____ _____
Witness Signature

EXHIBIT-E

(Disability Authorizations)

AUTHORIZATION FOR RELEASE OF DISABILITY CLAIMS RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all records of disability claims of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning:

_____
Name of Claimant

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requester
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____

_____
Claimant/Guardian/Personal Representative Signature
[NAME]

Date: _____

_____
Witness Signature

EXHIBIT-F

(Educational Authorizations)

AUTHORIZATION FOR RELEASE OF EDUCATIONAL RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all school records including, but not limited to, test results, test scores, report cards, or other school grading material, attendance records, physicals and other health-related, including but not limited to any physicians, nursing or allied health professional reports, records or notes, which may be in your possession.

_____
Name of Student

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requester
_____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgement at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____
Student
[NAME]

Date: _____ _____
Witness Signature

EXHIBIT-G

(Insurance Authorizations)

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

To: _____
Name of Insurer

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all forms regarding insurance claims applications and benefits and all medical, health, hospital, physicians, nursing or allied health professional reports, records, notes or invoices and bills, which may be in your possession.:

_____
Name of Insured

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

Records Requester
_____
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgement at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: _____ _____
Insured
[NAME]

Date: _____ _____
Witness Signature

EXHIBIT-H

(Federal Disclosure)

Federal Disclosure Requirements
(required by 42 U.S.C. § 1395y(b)(7) and (b)(8))

Starting on January 1, 2010, defendants must report to the federal government certain information about every plaintiff making a personal injury claim. Please complete the following form.

If you are filling this out in a representative capacity, the information should be for the user of the medication, not yourself.

Full Legal Name: _____

Date of Birth: _____

Gender: _____

Social Security Number: _____

Health Insurance
Claim Number (HICN): _____

Are you (or the person taking the medication) eligible to receive Medicare benefits?

Yes _____

No _____

If so, on what date did you (or the person taking the medication) become eligible to receive Medicare benefits?

_____

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA – ATLANTA DIVISION

IN RE: WRIGHT MEDICAL TECHNOLOGY, INC., CONSERVE HIP IMPLANT PRODUCTS LIABILITY LITIGATION	))))))	**MDL No. 2329** **1:12-MD-2329-WSD** **HON. WILLIAM S. DUFFEY, JR.**

PLAINTIFF FACT SHEET (Long Form)

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who had the Wright Conserve Hip Implant System (the "Device") implanted. Whether you are completing this Plaintiff Fact Sheet for yourself or for someone else, please assume that "You" means the person who had the Device implanted. In filling out this form please use the following definition: "healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In filling out any section or sub-section of this form, please submit additional sheets as necessary to provide complete information. In addition, if you learn that any of your responses are incomplete or incorrect at any time, please supplement your responses to provide that information as soon as you become aware of this information. This form requests information and documents about your medical condition for a specified period of time. However, defendants reserve the right to request additional information and information for a time period dating further back on a case by case basis, at which time the parties will meet and confer as the issue arises.

In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge, information and belief. If the response to any question is that the person completing this Plaintiff Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location(s). You may and should consult with your attorney if you have any questions regarding the completion of this form.[1]

[1] This Plaintiff Fact Sheet constitutes discovery responses subject to the Federal Rules of Civil Procedure.

I. CASE INFORMATION

1. Name of person completing this form: _____

2. Name of person on whose behalf a claim is being made: _____

3. Please state the following for the civil action that you filed:

   a. Case caption:_____
   b. Docket Number:_____
   c. Court in which action was originally filed:_____
   d. Name, address, telephone number, fax number and e-mail address of principal attorney representing you:
   Name:_____
   Firm:_____
   Address:_____
   Telephone Number:_____
   Fax Number:_____
   Email Address:_____

4. If you are completing this Plaintiff Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person), please complete the following:

   a. Your name, including other names you have used or by which you have been known and dates you used those names:

   _____

   b. Current Address: _____

   c. In what capacity are you representing the individual or estate: _____

   d. If you were appointed as a representative by a court, state the:

      Court which appointed you: _____

      Date of appointment:_____

   e. What is your relationship to the individual you represent: _____

   _____

   f. If you represent a decedent's estate, state:

      Date of Death: _____

THE REST OF THIS PLAINTIFF FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO WAS IMPLANTED WITH THE DEVICE

II. CORE INFORMATION

1. Type of Prosthesis:_____

   Side of body (please circle one): Right Left Both

Complete the questions in this section for each implant surgery involving a Conserve device.

2. Product Code/Lot Code for each Device (please attach a copy of the bar code stickers shown on the operative report):_____

   _____

   _____

3. Dates of Implantation:_____

4: Name and Address of Implanting Surgeon(s):_____

   _____

   _____

5. Name and Address of Hospital or Clinic where surgery(ies) performed: _____

   _____

6. If the Device(s) has been removed, provide the date on which it was removed: _____

   _____

7. Name and Address of Surgeon(s) who removed the Device(s): _____

   _____

8. Name and Address of Hospital or Clinic where surgery(ies) performed: _____

   _____

9. Name of the Manufacturer and size of the replacement device, if any: _____

   _____

   _____

10. a. Did you pay for your revision surgery and all related care?

Yes ☐ No ☐ In Part ☐

b. If No or In Part, state who or who else paid for the revision surgery: _____

_____

Provide the approximate amount paid by each person and entity and identify each person and insurance carrier, and for carriers, provide the name, address, and policy number.

_____

_____

_____

c. Did you pay for your initial surgery and all related care?

Yes ☐ No ☐ In Part ☐

d. If no, or in part, state who or who else paid for the surgery and all related care:

_____

_____

Provide the approximate amount paid by each person and entity and identify each person and insurance carrier, and for carriers, provide the name, address, and policy number.

_____

_____

_____

11. Were any of the components of the Device surgically removed? Yes ☐ No ☐

a. If Yes, what is the present location of the removed components of the Device?

_____

12. If you have not had any components of your Device removed surgically, do you presently plan to have any of the components removed?

Yes ☐ No ☐ Undecided ☐

If Yes, please state:

The date scheduled for the surgery to remove/replace the Device(s): _____

_____

The name of the surgeon: _____

_____

The name and address of the hospital where the surgery will be performed: _____

_____

The reason for the surgery: _____

_____

13. Has any doctor ever told you that you need to have any components of your Device removed?

Yes ☐ No ☐

If Yes please provide name and address of each such doctor: _____

_____

14. Has any doctor told you that your medical condition prevents you from having any components of your Device removed ?

Yes ☐ No ☐

If Yes please provide name and address of each such doctor: _____

_____

15. Have you received any other treatment or testing related to your Device?

Yes ☐ No ☐

If Yes, please state:

Date	Facility Name	Address and Telephone Number	Reason	Results

III. PERSONAL INFORMATION

1. Name (first, middle name or initial, last): _____

2. Maiden or other names used and dates you used those names:

_____

3. Current address and date when you began living at this address:

_____

4. Identify each address at which you resided for the period from five years before your first hip surgery up to the present and the dates you resided at each one.

Address	Dates of Residence

5. Social Security Number: _____

6. Date and place of birth: _____

7. Current marital status: _____

8. If married, please provide the following information:

Date of marriage: _____

Name of spouse: _____

Date and place of birth of spouse: _____

9. If married, has your spouse filed a loss of consortium or other claim in this action?

Yes ☐ No ☐

10. Name(s) of former spouse(s), date(s) of marriage(s) and dates the marriage(s) were terminated, and the nature of the termination (i.e., death, divorce):

_____

_____

11. If you have children, list each child's name and date of birth.

_____

_____

12. Identify all schools you attended, starting with high school:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or Primary Field

13. Are you currently employed? Yes ☐ No ☐

If yes, please identify your current employer with name, address and telephone number and your position there: _____

_____

If not, did you leave your last job for a medical reason? Yes ☐ No ☐

If Yes, describe why you left:

_____

_____

14. For the period of time from five years before you had your first hip surgery, until the present, please identify all of your employers, with name, address and telephone number, your employment dates, your position there, and your reason for leaving:

Name of Employer	Address and Telephone Number	Dates of Employment	Describe Your Position or Duties and Specify if Job Required Manual Labor	Reason for Leaving

15. For the period from five years before your first hip surgery until the present, please indicate if you have actively participated in any sports:

Yes ☐ No ☐

If Yes, please state:

Type of Sport	Dates/Years played	Approximate # of hours you played per week	Approximate # of hours you practiced per week

16. For the period from five years before your first hip surgery until the present, please indicate if you have regularly exercised:

Yes ☐ No ☐

If Yes, please state:

Type of Exercise	Dates/Years Exercised	Approximate # of hours You exercised per week	Period of times during which you performed this exercise (month/year)

17. Have you ever served in any branch of the military? Yes ☐ No ☐

Branch and dates of service: _____

If Yes, were you ever discharged for any reason relating to your medical or physical condition?

_____

If Yes, state what that condition was: _____

Have you ever been rejected from military service for any reason relating to your medical or physical condition? Yes ☐ No ☐

If Yes, state what that condition was: _____

18. If you have Medicare, please state your HICN number: _____

19. For the period from five years before your first hip surgery to the present, have you been on or applied for workers' compensation, social security, and/or state or federal disability benefits? Yes ☐ No ☐

If Yes, then as to each application, separately state the following and attach any documents you have which relate to the application and/or award of benefits:

a. Date (or year) of application: _____

b. Type of benefits: _____

c. Nature of claimed injury/disability: _____

d. Period of disability: _____

e. Amount awarded: _____

f. Basis of your claim: _____

g. Was claim denied? Yes ☐ No ☐

h. To what agency or company did you submit your application: _____

_____

i. Claim/docket number, if applicable: _____

20. Have you ever been involved in an accident or event, in which or as a result of which you suffered any personal injuries to your legs, hips or pelvic area? Yes ☐ No ☐

If Yes, please provide the following information and attach copies of any accident reports:

Place and Date of Accident	Circumstances, Nature, Location, and Extent of Injury	Nature of Activity at Time of Injury	Names and Addresses of Treating Physician(s)

21. a. Have you ever filed a lawsuit or made a claim against a healthcare provider or pharmaceutical company? Yes ☐ No ☐

b. Have you ever filed a lawsuit or made a claim against anyone related to any injury to your hip, pelvis or legs? Yes ☐ No ☐

If Yes to either (a) or (b) above, please provide the following information and attach copies of all pleadings, releases or settlement agreements and deposition transcripts you have:

Party You Sued/Made Claim Against	Court in Which Suit Filed/Claim Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

22. Have you ever been convicted of, or pled guilty to, a felony and/or a crime of fraud or dishonesty within the past ten years? Yes ☐ No ☐

If Yes, please state the charge to which you plead guilty or which you were convicted of, as well as the court where the action was pending: _____

_____

23. Have you or your spouse ever declared bankruptcy since the date of your original hip implantation surgery? Yes ☐ No ☐

If Yes, please state when and in what court you filed your bankruptcy petition, including the docket number of the petition and the orders of discharge:_____

_____

24. Have you or your spouse (if he/she is pursuing a loss of consortium claim) received any money from a third party in exchange for an assignment of any portion of your claim or recovery in this lawsuit, so that the payer or assignee has decision making authority over the terms of any settlement or other resolution of your claim or has lien rights (excluding liens by healthcare providers) against any funds generated by the resolution of your claim?

Yes ☐ No ☐

If Yes, please state:

The name and address of the third party with whom you have entered into such a contract. _____

_____

25. Since you received your Conserve hip prosthesis, have you publicly posted a comment, message or blog entry on a public internet site (e.g. no password required for access) in which you have discussed or described your Conserve experience, injury, disability, pain or physical complaints related to the Conserve hip? (You should include non-password protected postings on public social network site including Twitter, Facebook, MySpace, Linked In, or "blogs" where the general public may post Conserve related comments).

Yes ☐ No ☐

If so, please tell us where and when you made such public posts and the substance of what was posted. Do not include posting that were provided exclusively to your attorney or his/her representative. _____

_____

_____

_____

_____

IV. HEALTHCARE PROVIDERS

FOR ALL QUESTIONS IN THIS SECTION, MEN DO NOT HAVE TO PROVIDE DETAILS AS TO PROSTATE CONDITIONS, AND WOMEN DO NOT HAVE TO PROVIDE INFORMATION AS TO BIRTH CONTROL OR REPRODUCTIVE ISSUES (UNLESS THERE IS A CLAIM RELATED TO CHILD BEARING, AND THEN A FULL OBSTETRICAL AND GYNECOLOGIC HISTORY NEEDS TO BE PROVIDED).

1. Identify each doctor or healthcare provider (including but not limited to family/primary care physicians, orthopedic surgeons, physical therapists, chiropractors, practitioners of the healing arts) whom you have seen for medical care and treatment for the period five years before your first hip surgery to the present. (except for treatment for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

Name and Specialty	Address and Telephone Number	Approx Dates/Years of Visits	Reason

2. Identify each hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation centers where you have received medical treatment (in-patient, out-patient, or emergency room visit) for the period five years before your first hip surgery to the present. (except for treatment for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

Name	Address	Admission Date(s)	Reason	Type of Surgery (if applicable)	Name of Surgeon (if applicable)

3. Identify each facility at which radiographs (x-rays, ultrasounds, MRIs, CT scans) were taken in the last 10 years of your hips, pelvis or legs.

Name	Address and Telephone Number	Approx Date Taken	Reason

4. Identify each laboratory at which your blood was tested in the last 10 years for blood levels of any metals including cobalt and chromium.

Name	Address and Telephone Number	Approx Date Taken	Reason	Results (if known by you)

5. Identify each pharmacy, drugstore or any other facility or supplier (including but not limited to mail order pharmacies) where you ever received any prescription medication for the period five years before your first hip surgery to the present. (except for medicine for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

Name of Pharmacy/Supplier	Address and Telephone Number of Pharmacy/Supplier	Approx Dates/Years You Used Pharmacy/Supplier

V. MEDICAL BACKGROUND

1. Current Height:_____

2. Please state your weight at the following times:

   a. Current:_____

   b. Time of implant:_____

   c. Time of revision surgery (if any):_____

3. Smoking History

   a. Have you ever smoked cigarettes? Yes ☐ No ☐

   State brand(s) smoked: _____

   State amount smoked: _____ packs per day for _____ years, during the years

   _____ to _____.

   b. Have you ever smoked cigars or pipe tobacco or used smokeless tobacco?

   Yes ☐ No ☐

   State brand(s) smoked or chewed: _____

   State amount smoked/utilized: _____ cigars/pipes/smokeless tobacco per day for

   _____ years, during the years _____ to _____.

4. Alcohol/Drug Use

   a. For the period of time five years before your first hip surgery up to the present, set forth the amount and type(s) of alcoholic beverages you consume(d) on a weekly/monthly/yearly basis on average and the type. If the amount has materially changed over this period of time, please describe/explain.

   _____

   _____

   _____

b. For the period of time five years before your first hip surgery up to the present, have you ever taken cocaine, crack, heroin, LSD, amphetamines?

Yes ☐ No ☐

If Yes, identify which drug(s), amount and period of use: _____

_____

5. Allergies and Allergic Reactions

a. Have you ever experienced an allergic reaction to any food, medication, jewelry, or metal?

Yes ☐ No ☐

If Yes, please state the following:

Food, Medication, Jewelry or Metal	When Allergy Diagnosed	Symptoms of Allergy	Health Care Provider Who Diagnosed Allergy	Treatment Received, if any

6. Other Conditions

a. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions from the time beginning five years before your first hip surgery to the present? Please select Yes or No for each condition. For each condition for which you answer Yes, please provide the additional information requested in the table following this chart:

Condition Experienced or Diagnosed	Yes	No	Don't Know
1. Arthritis (e.g., osteoarthritis, traumatic arthritis, rheumatoid arthritis, degenerative arthritis)			
2. Neuromuscular compromise or vascular deficiency			
3. Poor bone quality (e.g., osteoporosis)			
4. Charcot's or Paget's disease			
5. Cancer (including blood cancers such as leukemia)			
6. Allergy, such as hay fever, asthma, eczema, hives, sensitivity to drugs or other substances, including allergic reactions to metal			

Condition Experienced or Diagnosed	Yes	No	Don't Know
7. Obesity			
8. Alcohol or drug addiction			
9. Any pathological condition of the acetabulum (e.g.,arthrokatadysis)			
10. Diabetes			
11. Infections lasting longer than a week or occurring more frequently than monthly			
12. Tumors or Pseudo-tumors			
13. Periarticular calcification or ossification			
14. Disabilities of joints (knees and ankles)			
15. Osteolysis			
16. Congenital dysplasia of the hip or subluxation or dislocation of the hip joint			
17. Peripheral neuropathies or nerve damage			
18. Acetabular perforation			
19. Femoral shaft perforation, fissure, or fracture			
20. Trochanteric fracture			
21. ALVAL			

b. For each condition for which you answered Yes in the previous chart, please provide the information requested below:

Condition You Experienced	Approximate Date of Onset	Name, Address and Telephone Number of Treating Physician (if any)	Treatment Received

VI. MEDICATIONS

FOR ALL QUESTIONS IN THIS SECTION, MEN DO NOT HAVE TO PROVIDE DETAILS AS TO PROSTATE CONDITIONS, AND WOMEN DO NOT HAVE TO PROVIDE INFORMATION AS TO BIRTH CONTROL OR REPRODUCTIVE ISSUES (UNLESS THERE IS A CLAIM RELATED TO CHILD BEARING, AND THEN A FULL OBSTETRICAL AND GYNECOLOGIC HISTORY NEEDS TO BE PROVIDED).

1. List all of the medications (prescription and over the counter) you currently take.

Medication	Dose/ Frequency/Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

2. To the best of your recollection, are there any prescription medications other than those identified that you have taken on a regular basis for any duration of more than two months for the period five years before your first hip surgery to the present? (except for treatment for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

Yes ☐ No ☐

a. If Yes, please identify the medication(s), the doctor(s) who prescribed it, the approximate dates/years you have taken this medication, and why it was given to you:

Medication	Dose/ Frequency/Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

VII. IMPLANT/REMOVAL

1. Describe the condition for which the Device was implanted:

_____

_____

_____

a. If this condition the result of an on-the-job injury? Yes ☐ No ☐

If Yes, please state:
Place of employment at the time:_____

Address:_____

Telephone number: _____

Job description/duties at the time: _____

Nature of accident: _____

2. Before the implantation of the Device, did you receive non-surgical treatment for your hip?

Yes ☐ No ☐

a. State the period during which you received non-surgical treatment:

_____

b. State the nature of the non-surgical treatment (*e.g.*, rest, physical therapy, medication, injections): _____

_____

c. State the name and address of all doctors or health care providers involved in your non-surgical treatment:

_____

_____

_____

3. Did you see, read or rely upon any documents or other information from Wright in making your decision to have the Device implanted? Yes ☐ No ☐

   a. If Yes, identify each document/source of information. _____

   _____

   b. When did you read the document/receive the information? _____

   _____

   c. How did you obtain the document or information? _____

   _____

   d. Do you have the document or written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff Fact Sheet. Yes ☐ No ☐ I don't know ☐

   If you no longer have the document or written information in your possession, please describe the information that you received to the best of your ability:

   _____

   _____

4. Were you given any verbal or written instructions, warnings or other information regarding the implantation of the Device? Yes ☐ No ☐ I don't know ☐

   a. If Yes, when did you receive the information? _____

   b. Who gave you the information? _____

   c. Do you have the written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff Fact Sheet. Yes ☐ No ☐ I don't know ☐

   d. Please describe the oral instructions/warnings you received to the best of your ability:

   _____

   _____

   _____

5. Have you had any communications with any present or former employee of Wright Medical Technology, Inc., Wright Medical Group, Inc., or any Wright Medical Conserve distributor or sales representative concerning the Device or matters in any way related to this lawsuit? Yes ☐ No ☐

If Yes, for each, please state:

Date of Communication	Name of Person with Whom You Communicated	Mode of Communication (In Person, By Phone, By Email, By Mail)	Do you have a writing or recording? (IF SO, PLEASE ATTACH)

If the communication was by phone or in-person, please tell us what was said:

_____

_____

_____

VIII. INJURIES & DAMAGES

1. Are you claiming any physical injuries or illness as a result of the Device?

Yes ☐ No ☐

If Yes, please describe in detail the following:

a. The physical injuries or illness claimed and when the symptoms began: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

b. Are those injuries or illnesses continuing? Yes ☐ No ☐

c. Provide the approximate date of treatment for each condition, and identify the name and address of each health care provider that you have seen for these problems:

Condition You Experienced	Approximate Date of Treatment	Name, Address and Telephone Number of Health Care Provider (if any)

d. Have you ever been hospitalized as a result of any of these conditions?

Yes ☐ No ☐

If Yes, please provide the following information:

i. Approximate date(s) of hospital admission: _____

ii. Approximate date(s) of discharge: _____

iii. Hospital names(s) and address(es):_____

2. Do you claim any psychological or psychiatric injury (other than garden variety emotional distress) as a consequence of having the Device?

Yes ☐ No ☐

If Yes, please state the following as it pertains to your treatment for any psychiatric and/or psychological condition(s):

Condition	Name and Address of Mental Healthcare Provider (if any)	Approx. Dates/Years of Treatment/Visits (if any)

3. Are you making a claim for lost wages or lost earning capacity?

Yes ☐ No ☐

a. If yes, describe your claim and attach your W-2 forms for the past (5) years. Your description should include the total amount of time (and amount of income) which you have lost or will lose from work as a result of any condition which you claim or believe was caused by the Device, and an explanation of how those amounts were calculated:

_____

_____

_____

_____

b. If you claim a loss of earnings, state your earned income from work for the following years:

YEAR	INCOME
2010	$
2009	$
2008	$
2007	$
2006	$
2005	$

IX. MEDICAL AND OUT-OF-POCKET EXPENSES

1. State the amount of medical expenses, by provider, which you have incurred, including amounts billed to insurers and other third party payors, which are related to any condition which you claim or believe was caused by the Device for which you seek recovery in this action:

Name and Address of Provider	Dates of Treatment	Amount of Medical Expenses
		$
		$
		$
		$
		$

For any expenses claimed above, have they been reimbursed by any third party?

Yes ☐ No ☐

If Yes, identify which expenses, the amount reimbursed and the date reimbursed.

_____

_____

X. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. Are you filling this out on behalf of an individual who is deceased?

Yes ☐ No ☐

If Yes, please state the following from the Death Certificate of the individual, and attach a copy of the letter of administration: (NOTE: In lieu of the following, please attach a copy of the death certificate)

Date of death: _____

Place of death (city, state and country): _____

Facility or location where death occurred: _____

_____

Name of physician who signed death certificate: _____

Cause of death: _____

2. Are you filling this out on behalf of an individual who is deceased and on whom an autopsy was performed?

Yes ☐ No ☐

If Yes, please attach a copy of the autopsy report.

XI. FACT WITNESSES

Please identify all persons whom you believe possess information concerning you injury(ies) and current medical conditions, other than your healthcare providers, and please state their name, address, and relationship to you:

Name: _____

Address: _____

Relationship to you: _____

Name: _____

Address: _____

Relationship to you: _____

Name: _____

Address: _____

Relationship to you: _____

Name: _____

Address: _____

Relationship to you: _____

Name: _____

Address: _____

Relationship to you: _____

XII. DOCUMENT DEMANDS

These document requests are not intended to seek attorney client communications, or attorney work product materials. In addition, these requests do not encompass or seek information about expert witnesses or communications with and/or from experts or proposed trial exhibits or trial materials which may be subject to disclosure at a later date in accordance with subsequent Court Order or rule. Thus, if you have any of the following in your possession which is not protected as set forth above, please provide a copy of it with this Plaintiff Fact Sheet.

REQUEST NO. 1: All medical records from any physician, hospital or health care provider who has treated you for any injury, illness and/or disease identified in response to this Plaintiff Fact Sheet.

REQUEST NO. 2: All radiographs (x-rays, ultrasounds, MRIs, CT scans) that relate to the condition and injuries alleged in plaintiff's complaint, show any portion of plaintiff's hip and/or depict the Device.

REQUEST NO. 3: All laboratory reports and results of blood tests performed on plaintiff that show the level of cobalt and chromium ion levels in the blood.

REQUEST NO. 4: All medical bills for which plaintiff seeks recovery in this lawsuit, as well as all documents relating to third-party payments of medical bills.

REQUEST NO. 5: All records of any other expenses allegedly incurred as a result of the injuries alleged in the complaint.

REQUEST NO. 6: All photographs and videos of plaintiff's surgery and all photographs and videos of plaintiff which show plaintiff's condition since the date of the original implantation

REQUEST NO. 7: Any documents including but not limited to literature or warnings received by you from surgeons, physicians, or other health care professionals who have treated you for any condition related to the Device.

REQUEST NO. 8: Any documents including diaries, journals, calendars, emails, texts, postings on websites, blogs, and social media accounts (e.g. Facebook, MySpace, or Twitter) or other notes prepared by plaintiff or plaintiff's representative, other than plaintiff's attorneys, concerning Wright, and plaintiff's physical and emotional health.

REQUEST NO. 9: All materials you received concerning the nature of the Device, whether created by Wright, your health care provider, or any other third party.

REQUEST NO. 10: Decedent's death certificate, letter of administration, and/or autopsy report (if applicable).

REQUEST NO. 11: All bankruptcy petitions and orders of discharge (if applicable) for all bankruptcy claims made by you or your spouse since the date of your first hip surgery.

XIII. AUTHORIZATIONS

Complete and sign the attached Authorizations.

XIV. VERIFICATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge upon information and belief, that I have supplied all the documents requested in part XII of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration.

Date:_____ Signature:_____

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO: _____
Patient Name: _____
DOB: _____
SSN: _____

I, _____ , hereby authorize you to release and furnish to Duane Morris LLP and/or their duly assigned agents copies of the following information:

- All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss any aspect of the above named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: _____ (plaintiff/representative)

Signature: _____ Date _____

IN RE: BAYCOL LITIGATION
MDL No. 1431

PLAINTIFF'S FACT SHEET

Each Plaintiff who used Baycol must complete this Fact Sheet. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You may and should consult with your attorney if you have any questions regarding the completion of this form.

If you are completing the form for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person. You may attach as many sheets of paper as necessary to answer these questions.

I. Case Information

A. Please state the following for the civil action that you filed:

1. Case caption:_____

2. Civil Action No:_____

3. Court in which action was originally filed:_____

4. Name, address, telephone number, fax number and e-mail address of principal attorney representing you:

_____
Name

_____
Firm

_____
Street Address

_____
City, State and Zip Code

_____
Telephone Number Fax Number

_____
E-mail address

B. If you are completing this Fact Sheet in a representative capacity (on behalf of the estate of a deceased person or a minor), please state:

1. Your name:_____

2. Address:_____

3. In what capacity are you representing the person?_____

4. If a court appointed you to act on behalf of the estate of the deceased person or minor, state the court and date of appointment:_____

_____

5. Your relationship to deceased or represented person:_____

6. If you represent a decedent's estate, state the date of decedent's death:_____

_____

The remainder of this Fact Sheet requests information about the person who used the Baycol. If you are completing this Fact Sheet for someone else, please assume that "you" means the person who used Baycol.

II. Personal Information

A. Name:_____

B. Have you ever used any other names and, if so, when:_____

_____

C. Current Address:_____

D. How long have you been living at this address?_____

E. List any prior addresses during the last ten (10) years and the dates when you lived at those addresses. If you cannot recall all of the details regarding those addresses, please provide as much information as you can._____

_____

_____

_____

_____

_____

_____

F. Social Security Number:_____

G. Date and place of birth:_____

H. Sex: Male____ Female_____

I. Marital Status:_____

J. If applicable, name of current spouse and date of marriage:_____

_____

K. If applicable, name of former spouse(s) and date(s) of marriage within the last ten (10) years:_____

_____

_____

L. Name(s) of children and date(s) of birth, if applicable:_____

_____

_____

_____

_____

_____

_____

M. Current employer:

Name:_____
Address:_____
Job Duties:_____
Job Title:_____
Dates Employed:_____
Full-time or Part-time:_____
Name of Supervisor:_____

Are you making a claim for lost wages or lost earning capacity? _____ Yes _____ No

N. Please complete the following information regarding any employers (other than your current employer) that you have had in the last ten (10) years:

1. Name:_____
Address:_____
Job Duties:_____
Job Title:_____
Dates Employed:_____
Full-time or Part-time:_____
Reason for Leaving:_____
Name of Supervisor:_____

2. Name:_____
Address:_____
Job Duties:_____
Job Title:_____
Dates Employed:_____
Full-time or Part-time:_____
Reason for Leaving:_____
Name of Supervisor:_____

O. Please provide the following information about your education:

1. High School

Name:_____
Address:_____
Grade completed:_____
Year graduated:_____

2. Did you attend school beyond high school? _____ Yes _____ No

If "yes," please complete the following for each school that you attended after high school:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or primary field

P. Have you used a computer at any time during the past five (5) years?
_____ Yes _____ No

If "yes," please complete the following:

1. Did you have e-mail? _____ Yes _____ No

2. Did you have internet access? _____ Yes _____ No

3. Have you ever visited any website containing information regarding Baycol, statins or the treatment of high cholesterol or high triglycerides?

_____ Yes _____ No _____ I don't know

4. Have you ever visited any chat rooms where Baycol, statins, or the treatment of high cholesterol or high triglycerides was discussed?

_____ Yes _____ No _____ I don't know

5. Have you ever communicated via e-mail or chat room about Baycol, statins or the treatment of high cholesterol or high triglycerides?

_____ Yes _____ No _____ I don't know

Q. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf in the ten (10) years before you took Baycol through the present?

_____ Yes _____ No

If "yes, please complete the following:

Name of Company	Address

R. Have you applied for worker's compensation, social security, or state or federal disability benefits in the past ten (10) years?

_____ Yes _____ No

If "yes," please complete the following for each application. If you cannot recall all of the details regarding such application(s), please provide as much information as you can.

1. Date (or year) of application:_____
2. Type of benefits:_____
3. Amount awarded:_____
4. Basis of your claim:_____
5. If denied, reason for denial:_____
6. To what agency or company you submitted your application (*e.g.*, Pennsylvania Division of Social Security):_____

S. Were you ever rejected or discharged from military service for any reason relating to your health or physical condition?

_____ Yes _____ No

If "yes," then state the reason for the health-related rejection or discharge and when this happened.

_____

_____

T. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury, illness or physical harm?

_____ Yes _____ No

If "yes," please state the court in which the lawsuit was brought and the civil action or docket number assigned to each such claim, action, or lawsuit. If you cannot recall all of the details, please provide as much information as you can.

_____

_____

III. Your Health Care Providers

A. Please provide the following information for each doctor, clinic or healthcare provider that you have seen or who has treated you during the last ten (10) years. If you cannot recall all of the details regarding the healthcare providers that you have seen, please provide as much information as you can.

1. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

2. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

3. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

4. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

5. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

6. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

7. Name:_____
Specialty, if any:_____
Address:_____
Phone:_____
Reason(s) for visit(s):_____
_____
Medications prescribed or recommended:_____
_____

[ATTACH ADDITIONAL PAGES, IF NECESSARY]

IV. Your Medical Background

A. Height:_____

B. Current Weight:_____

C. Your Smoking History

1. Never smoked cigarettes _____

2. Past smoker of cigarettes _____
Date on which smoking ceased _____
Amount smoked: _____ packs per day for _____ years

3. Current smoker of cigarettes_____
Amount smoked: _____ packs per day for _____ years

4. Have you ever used any other form of tobacco (snuff, dipping, cigars)?

_____ Yes _____ No _____ I don't know

If "yes," please identify:

a. What form:_____
b. Dates of use:_____
c. Amount of use:_____

D. Alcohol Consumption

On average, how much alcohol do you drink?

_____ None
_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 10 or more drinks per week

E. Please provide the following information for each hospitalization that you have had during the last ten (10) years. If you cannot remember all of the details, please list as much information as you can.

1. Name of hospital:_____
Address:_____
Phone:_____
Reason(s) for hospitalization(s):_____
_____
_____

2. Name of hospital:_____
Address:_____
Phone:_____
Reason(s) for hospitalization(s):_____
_____
_____

3. Name of hospital:_____
Address:_____
Phone:_____
Reason(s) for hospitalization(s):_____
_____
_____

[ATTACH ADDITIONAL PAGES, IF NECESSARY]

F. Please complete the following information for each surgery that you had in the last ten (10) years. If you cannot remember all of the details, please list as much information as you can.

1. Name of operation:_____
Name of surgeon:_____
Address of surgeon:_____
Reason for surgery:_____

2. Name of operation:_____
Name of surgeon:_____
Address of surgeon:_____
Reason for surgery:_____

3. Name of operation:_____
Name of surgeon:_____
Address of surgeon:_____
Reason for surgery:_____

[ATTACH ADDITIONAL PAGES, IF NECESSARY]

G. If you have ever consulted a doctor, clinic or other healthcare provider concerning any kidney condition, illness or disease including kidney failure, polynephritis, nephrosclerosis, kidney stones, proteinuria or hematuria (blood in the urine), please complete the following. If you cannot remember all of the details, please list as much information as you can.

Name of doctor or facility:_____
Address:_____
Date:_____
Diagnosis:_____
Treatment:_____
Medications:_____
Did condition resolve?_____
Current status of condition:_____

H. If you have ever consulted a doctor, clinic or other healthcare provider concerning any liver condition, illness or disease including but not limited to hepatitis, cirrhosis or fatty liver, please complete the following. If you cannot remember all of the details, please list as much information as you can.

Name of doctor or facility:_____
Address:_____
Date:_____
Diagnosis:_____
Treatment:_____
Medications:_____
Did condition resolve?_____

Current status of condition:_____

I. If you have ever consulted a doctor, clinic or other healthcare provider about any musculoskeletal condition or disease including muscle pain or weakness, extreme fatigue, myopathy, polymyositis, fibromyalgia, arthritis, tendonitis, or other muscle related concerns or problems, please complete the following. If you cannot remember all of the details, please list as much information as you can.

Name of doctor or facility:_____
Address:_____
Date:_____
Diagnosis:_____
Treatment:_____
Medications:_____
Did condition resolve?_____
Current status of condition:_____

J. Have you had any of the following tests or procedures in the past ten (10) years?

Test/ Procedure	**Yes**	**No**	**I don't know**
Creatine kinase (CK)/ Creatine phosphokinase (CPK)			
EMG/Nerve conduction Studies			
Cystoscopy			
Liver biopsy			
Other diagnostic test(s) or imaging of the kidneys, liver or muscles			

If "yes," please complete the following. If you cannot remember all of the details, please list as much information as you can.

a. Type of test:_____
b. Date administered:_____
c. Reason for test:_____
d. Facility name and address:_____
e. Ordering doctor:_____
f. Results/diagnosis:_____
g. Treatment:_____

[ATTACH ADDITIONAL PAGES, IF NECESSARY]

K. Have you been tested for any of the following in the last ten (10) years:

Condition	**Yes**	**No**	**I don't know**
Diabetes			
Atherosclerosis			

Condition	Yes	No	I don't know
Myocardial infarction/ heart attack			
Abnormal heart rhythm			
Congestive heart failure			
Angina			
Thyroid disorder			
Autoimmune disease			

If you responded "yes" to any of the above, complete the following information for each condition. If you cannot remember all of the details, please list as much information as you can.

a. Type of condition and date of testing:_____
Testing doctor:_____
Treatment:_____

b. Type of condition and date of testing:_____
Testing doctor:_____
Treatment:_____

c. Type of condition and date of testing:_____
Testing doctor:_____
Treatment:_____

L. Have you ever been diagnosed as having:

Condition	Yes	No	I don't know
High cholesterol			
Elevated trigylcerides			
Hypertension/high blood pressure			
Obesity			
Diabetes			
Thyroid disorder			
Autoimmune disease			
Abnormal heart rhythm			
Congestive heart failure			
Angina			
Myocardial infarction			
Atherosclerosis			

If you responded "yes" to any of the above, please complete the following information for each condition. If you cannot remember all of the details, please list as much information as you can.

a. Condition and date of diagnosis:_____
Name of diagnosing doctor:_____
Treatment:_____

b. Condition and date of diagnosis:_____
Diagnosing doctor:_____
Treatment:_____

c. Condition and date of diagnosis:_____
Diagnosing doctor:_____
Treatment:_____

V. Baycol

A. Have you ever taken Baycol? _____ Yes _____ No

If "yes," then complete the following:

Dates of use	Dosage	Prescribed by (name and address)	Dispensing pharmacy (name and address)

B. Were you given any **written** instructions, warnings or other information regarding your use of Baycol?

_____ Yes _____ No _____ I don't know

1. If "yes," when did you receive the information?_____

2. Who gave you the information?_____

3. If you no longer have the written information in your possession, please describe the written information that you received to the best of your ability._____
_____
_____

C. Were you ever given any **oral** instructions, warnings or other information regarding your use of Baycol?

_____ Yes _____ No _____ I don't know

1. If "yes," when did you receive them?_____

2. Who gave them to you?_____

3. Please describe the oral instructions you received to the best of your ability._____
_____
_____

D. Please list any prescription or over-the-counter drug, any dietary supplement, vitamin, or herbal remedy that you were taking at the same time you were taking Baycol.

Name of Drug	Date(s) Taken	Prescribing Doctor	Name and Address of Pharmacy Where Obtained

VI. Physical Injuries, Illness and Damages

A. If you are making a claim for physical injuries or illness from taking Baycol, please describe the following:

1. Nature of physical injuries or illness:_____
_____

2. The date that you first became aware of the physical injuries or illness:_____
_____

3. How you first became aware of the physical injuries or illness: _____
_____

4. Whether those injuries or illnesses are continuing:_____
_____
_____

Did you see a doctor, clinic or other healthcare provider for the physical injuries or illness listed above?

_____ Yes _____ No _____ I don't know

If "yes," please complete the following for each healthcare provider:

a. Name:_____
b. Address:_____

c. Date of first consultation with that healthcare provider:_____
d. Date of last consultation:_____
e. Do you plan to continue to consult with that healthcare provider? ____Yes ___No

B. Have you had any discussions with any doctor or other healthcare provider about whether Baycol contributed to your physical injuries or illness?

_____ Yes _____ No

If "yes," provide the doctor's or healthcare provider's name and address, and the date of that discussion._____
_____
_____

C. If you are making claims for out-of-pocket expenses as a result of taking Baycol, please complete the following:

1. For what:_____

2. Amount of fees or expenses:_____

3. Person or company paid or to be paid:_____

D. If you are making a claim for emotional distress or psychological injuries, please complete the Supplemental Fact Sheet for Claims of Emotional Distress and Psychological Injuries and Harm.

E. Are there persons (other than those already identified in this Fact Sheet) whom you believe are witnesses to your claimed injuries or damages? If yes, please provide their name(s) and address(es):

1. _____
2. _____
3. _____
4. _____
5. _____

VII. Other Medications

Have you taken any of the following medications during the past ten (10) years? If you cannot recall all of the details requested, please provide as much information as you can.

Drug	Yes	No	I don't know	If yes, date(s) taken and prescribing doctor	Name and address of pharmacy where obtained
CHOLESTEROL-LOWERING DRUGS					
Lescol [Fluvastatin]					
Lipitor [Atorvastatin]					
Mevacor [Lovastatin]					
Pravachol [Pravastatin]					
Zocor [Simvastatin]					
Niacin [Vitamin B3]					
LoCholest [Cholestyramine]					
Questran [Cholestyramine]					
Prevalite [Cholestyramine]					
TRIGLYCERIDE-LOWERING DRUGS					
Lopid [Gemfibrozil]					
Tricor [Femofibrate]					
Bezafibrate					
Ciprofibrate					
ANTI-INFECTIVE DRUGS					
Diflucan [Fluconazole]					
Erythrocin & Others [Erythromycin]					
Flagyl [Metronidazole]					
Nizoral [Ketoconazole]					
Sporanox [Itraconazole]					
IMMUNO-SUPPRESSIVE DRUGS					
Neoral [Cyclosporine]					
Sandimmune [Cyclosporine]					
OTHER					
Anticoagulants					
Heart Drugs					
Thyroid Medications					
Other					

VIII. Family History

A. To the best of your knowledge have any of your children, parents, grandparents or siblings had diabetes, any type of kidney or liver disease, or any type of muscle disorder?

_____ Yes _____ No _____ I don't know

B. If "yes," please complete the following:

Relative's name:_____
Relationship to you:_____
Type of health problem:_____
Date and cause of death, if applicable:_____

Relative's name:_____
Relationship to you:_____
Type of health problem:_____
Date and cause of death, if applicable:_____

Relative's name:_____
Relationship to you:_____
Type of health problem:_____
Date and cause of death, if applicable:_____

Relative's name:_____
Relationship to you:_____
Type of health problem:_____
Date and cause of death, if applicable:_____

IX. Documents

Please provide a copy of all of your documents and things which fall into the categories listed below. This includes documents and things in your personal possession, as well as items being held for you by another person, including your lawyer or any relative.

1. A copy of all medical records (excluding psychiatric or psychological records) from any physician, hospital, clinic, healthcare provider or pharmacy that treated you, or filled your prescriptions, in the last ten (10) years.

2. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

3. All instructions, product warnings, package inserts, advertising materials, pamphlets, magazine or newspaper articles, internet information, promotional materials, any documents or materials from defendants, or pharmacy handouts that you have regarding Baycol.

4. Copies of the entire packaging, including the bottle, box and label for the Baycol you allege caused you injury and any remaining medication.

5. If you are claiming lost wages or a loss of earning capacity, your federal tax returns for each of the last five (5) years.

6. If you claim any loss from medical expenses, copies of all bills for which you are seeking reimbursement from any physician, hospital, pharmacy or other health care provider.

7. Copies of letters testamentary or letters of administration relating to your status as plaintiff.

8. Decedent's death certificate (if applicable).

9. All documents of any kind related to other drugs that you took at the same time you were taking Baycol.

X. Authorizations

Complete and sign the attached Authorization for Release of Medical Records (No Psychological Injuries Claimed), and attached Authorization for Release of Employment and Unemployment Records (No Psychological Injuries Claimed).

If you have filed a Workers' Compensation or Social Security disability claim, please complete and sign the attached Authorization for Release of Workers' Compensation and Social Security Records.

XI. Declaration

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in Part IX of this Plaintiff's Fact Sheet, as required above.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

_____ _____

Dated Signature

IN RE: BAYCOL LITIGATION
MDL No. 1431

SUPPLEMENTAL FACT SHEET FOR CLAIMS OF
EMOTIONAL DISTRESS AND PSYCHOLOGICAL INJURIES AND HARM

I. Are you making a claim for mental, emotional, psychological or psychiatric injuries or illness from your use of Baycol? ____ Yes ____ No

II. If you are making a claim for mental, emotional, psychological or psychiatric injuries or illness from your use of Baycol, please provide the following information:

1. Nature of the injury or illness:_____
_____

2. The date you first became aware of this injury or illness:_____
_____

3. How you first became aware of this injury or illness:_____
_____

4. Whether (and if so, how) this injury or illness has changed over time:_____
_____
_____

III. If you have seen a doctor, clinic or any other healthcare provider for treatment of this mental, emotional, psychological or psychiatric injury or illness, please provide the following information:

1. Name:_____
2. Address:_____
3. Date of first consultation with that healthcare provider:_____
4. Date of last consultation:_____
5. Do you plan to continue to consult with that healthcare provider? ____Yes ___No

IV. Have you had any discussions with any doctor or other healthcare provider about whether Baycol contributed to your physical injuries or illness?

_____ Yes _____ No

If "yes," provide the doctor's or healthcare provider's name and address, and the date of that discussion._____
_____
_____

V. If you have experienced or have been treated for any mental, emotional, psychological, or psychiatric condition or problem (including depression) prior to your use of Baycol, please complete the following:

Condition or problem for which treated	Dates of treatment	Treatment provider (name and address)

VI. Documents

Please provide a copy of all of your documents and things which fall into the categories listed below. This includes documents and things in your personal possession, as well as items being held for you by another person, including your lawyer or any relative.

1. A copy of all psychiatric or psychological medical records from any physician, hospital, clinic, healthcare provider that treated you in the last ten (10) years.

VII. Authorization

Complete and sign the attached Authorization for Release of Medical Records (Psychological Injuries Claimed), and attached Authorization for Release of Employment and Unemployment Records (Psychological Injuries Claimed).

VIII. Declaration

I declare under penalty of perjury that all of the information provided in this Plaintiff's Supplement Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in Part VI of this Plaintiff's Supplemental Fact Sheet, as required above.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

_____ _____

Dated Signature